STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012355	A. BUILDING _____ B. WING _____	12/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN 47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS The following State Residential findings cited are in accordance with 410 IAC 16.2.	R 000		
R 241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. This RULE is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physicians' orders were followed, related to medications not held as ordered, medications not given as ordered, weights not completed as ordered, oxygen not administered as ordered, and laboratory (lab) tests not completed as ordered for 3 of 6 residents reviewed for physicians' orders in a total sample of 6. (Residents #105, #124, and #132) Findings include: 1. Resident #132 record was reviewed on 12/18/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and osteoporosis. The Physician's Recapitulation Orders, dated 12/12, indicated an order for a BMP (Basic Metabolic Panel) (electrolytes) every six months and alternate with a CMP (Comprehensive Metabolic Panel) (more comprehensive electrolyte test) every six months, lipid panel every six months, and a fasting iron panel every	R 241		

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R 241	Continued From page 1 three months. The record indicated the last lab tests were completed on: lipid panel completed was on 10/27/11 fasting iron panel was on 11/13/11 BMP was on 11/14/11 then on 8/24/12. There was a lack of documentation a CMP had been completed on the resident During an interview on 12/18/12 at 2:30 p.m., the Medical Records LPN indicated the labs had not been obtained as ordered. 2. Resident #124's record was reviewed on 12/18/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and pulmonary fibrosis. The Physician's Recapitulation Orders, dated 12/12, indicated an order, dated 09/20/12 for daily weight and report edema or a weight gain of 11 pound or loss of 6.6 pounds to the Nephrologist. The Vital Signs and Weight Record indicated the resident's weight had been obtained on 10/12 and 11/12. There was a lack of documentation to indicate the resident's weight had been obtained daily as ordered. During an interview on 12/18/12 at 10:10 a.m., LPN #16 indicated the resident gets weighed at dialysis three times a week. She indicated a daily weight was not getting done at the facility. 3. Resident #105's record was reviewed on	R 241		

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R 241	Continued From page 2 12/18/12 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia, atrial fibrillation, and anemia. A) The Physician's Recapitulation Orders, dated 12/12, indicated the resident was to receive a CMP and a CBC (complete blood count) every three months. The last CBC results in the record was dated 08/21/12. There was a lack of documentation in the record to indicate a CMP had been completed. During an interview on 12/18/12 at 11:40 a.m., LPN #16 indicated the CBC's and CMP's had not been completed as ordered. B) The Physician's Recapitulation Orders, dated 12/12, indicated an order (10/28/11) for verapamil (heart medication) 240 milligrams daily, hold the medication if the pressure is less than 100/50 or the pulse is less than 60. The Medication Administration Record (MAR), dated 10/12, indicated the resident's blood pressure and pulse had not been obtained on October 1, 2, 3, 6, 7, 15, 16, 18, 22, 24, 26, 27, 28, 29, 2012. The 10/12 MAR indicated the resident's pulse had not been obtained on October 10, 14, 17, 19, 20, and 21, 2012. The 10/12 MAR indicated the resident's blood pressure was 88/54 on 10/10/12 and the verapamil had been administered. The MAR, dated 11/12, indicated the resident's blood pressure and pulse had not been obtained	R 241		

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R 241	Continued From page 3 on November 1, 3, 4, 5, 7, 13, 14, 15, 19, 22, 23, 27, 28, and 29, 2012. The 11/12 MAR indicated the resident's pulse had not been obtained on November 2, 21, 24, 25, and 26, 2012. The 11/12 MAR indicated the resident's pulse was 58 on 11/8/12 and the verapamil was given and the blood pressure was 92/50 on 11/17/12 and 98/48 on 11/18/12 and the verapamil had been administered. The MAR, dated 12/12, indicated the resident's pulse had not been obtained on December 1, 2, 3, 5, 8, 9, and 11, 2012. During an interview on 12/18/12 at 11:15 a.m., LPN # 16 indicated the blood pressures and pulses had not been obtained as ordered. She indicated the verapamil may have been held on November 8, 17, and 18, 2012 and she just didn't circle the initials (indicates medication not given) on the MAR. She indicated she could not remember. During an interview on 12/18/12 at 11:15 a.m., QMA #17 indicated she should have held the verapamil on 11/8/12 when the resident's pulse was 58. C) During the initial tour on 12/11/12 at 9 a.m. with CNA #18, Resident #105 was sitting in the lounge. The resident did not have oxygen on. During an observation on 12/18/12 at 9:15 a.m., the resident was in his wheelchair in his room. The resident did not have oxygen on. The Physician's Recapitulation Orders, dated	R 241		

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R 241	Continued From page 4 12/12, indicated an order for oxygen at 2 liters per minute continuous. During an interview on 12/18/12 at 11:15 a.m., LPN #16 indicated the resident should have his oxygen on. During an observation on 12/18/12 at 12 p.m., the resident was sitting in the lounge and did not have his oxygen on. D) Resident #105's Physician Recapitulation orders, dated 12/12, indicated an order (10/28/11) for timolol (glaucoma) eye drops, one drop in both eyes daily. The MAR, dated 11/12, indicated the resident had not received the eye drops on November 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 16, 19, 20, 21, 22, 23, 24, 25, and 26, 2012. The MAR, dated 12/12, indicated the resident had not received the eye drops on December 2, 3, 4, 11, 12, 13, 14, 15, 16, 17, and 18, 2012. During an interview on 12/18/12 at 11:15 a.m., LPN #16 indicated the eye drops were not signed as given.	R 241		
R 246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes	R 246		

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R 246	Continued From page 5 indicating the time and date of the contact. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure a QMA received authorization to give an as needed (PRN) medication prior to administering the medication for 2 of 6 residents reviewed for PRN medication in a total sample of 6. (Residents #105 and #107) (QMA #15, #17, and #19) Findings include: 1. Resident #105's record was reviewed on 12/18/12 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia, atrial fibrillation, and anemia. The Physician's Recapitulation Orders, dated 12/12, indicated an order (8/14/12) for albuterol (breathing medication) 0.83% per nebulizer every four hours as needed, (07/26/12) ipratropim BR (breathing) 0.02% per nebulizer four times a as needed, and (5/ 25/12) anti-diarrhea 2 milligrams (mg) one tablet orally as needed with a maximum of 16 mg in a day. The Medication Administration Record (MAR), dated 09/12, indicated QMA #15 gave the as needed anti-diarrhea on 09/01/12, the ipratropim on September 5, 26, and 29, 2012, and the albuterol on September 5, 26, and 29, 2012. There was a lack of documentation to indicate the QMA had obtained authorization from a licensed nurse prior to the administration of the medications. The MAR, dated 10/12, indicated QMA #15 administered the as needed albuterol and	R 246		

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R 246	Continued From page 6	R 246		

ipratropim on 10/8/12 without prior authorization of a licensed nurse prior to the administration of the medication.

The MAR, dated 12/12, indicated QMA #19 administered the as needed albuterol on December 6 and 14, 2012 and the anti-diarrhea on December 13, 2012 without prior authorization of a licensed nurse prior to the administration of the medication.

2. Resident #107's record was reviewed on 12/18/12 at 2 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia with psychosis.

The Physician's Recapitulation Orders, dated 12/12, indicated orders for (4/9/12) acetaminophen 325 mg, two tablets as needed every 4-6 hours for pain or fever, Hydrocodone (pain medicine) 5/325 mg, one tablet every four hours as needed for pain, and lorazepam (anti-anxiety) 0.5 mg every 24 hours for severe breakthrough anxiety/agitation.

The MAR, dated 11/12, indicated QMA #19 administered the hydrocodone on November 26, 28, and 29, 2012 and administered the lorazepam on November 13 and 25, 2012 without prior authorization of a licensed nurse prior to the administration of the medication.

The MAR, dated 12/12, indicated QMA #17 administered the acetaminophen on December 7, 10, and 14, 2012 without prior authorization of a licensed nurse prior to the administration of the medication.

During an interview on 2:05 p.m., QMA #19 indicated she did not think she needed to have

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R 246	Continued From page 7 prior authorization in an Assisted Living facility.	R 246		
R 410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident received a yearly tuberculin (TB) skin test (test for tuberculosis) for 1 of 6 resident's reviewed for TB tests in a total sample of 6. (Resident #132) Findings include: Resident #132 record was reviewed on 12/18/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and osteoporosis.	R 410		

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R 410	Continued From page 8 The Immunization Record indicated the resident received her first step TB test on 10/24/11 and a second step TB test on 11/09/11. The record lacked documentation to indicate the resident had received a yearly TB test by in 2012. During an interview on 12/18/12 at 2:30 p.m., the Medical Records LPN indicated the TB test had not been completed yearly.	R 410		